# AD HOC COMMITTEE TO DEFEND HEALTH CARE

**Memorandum**

**To:** Senator Mark Montigny
Chair, Senate Ways and Means
Co-Chair, Advisory Committee on Consolidated Health Care Financing
State House, Room 212
Boston, MA 02133

Representative Nancy Flavin
Assistant Vice Chair, House Ways and Means
Co-Chair, Advisory Committee on Consolidated Health Care Financing
State House, Room 238
Boston, MA 02133

**From:** John D. Goodson M. D.
Advisory Committee representative
Ad Hoc Committee to Defend Health Care

**Date:** December 30, 2002

**Re:** **Comments on the Report to the Legislature by LECG, LLC, Mercer Government Human Services Consulting and McDonell Consulting: *The Feasibility of Consolidated Health Care Financing and Streamlined Health Care Delivery in Massachusetts***

The Advisory Committee on Health Care Financing was the direct outcome of the Ad Hoc Committee's efforts in 2000 to accelerate health care reform in Massachusetts. As the author organization and principle coalition member of those health care activists who sponsored the ballot initiative, Question 5, that stimulated the Legislature to pass the Managed Care Reform Act of 2000, we have a special interest in the outcome of all efforts to bring universal health care coverage to the residents of our state.

We continue to feel that it is immoral and uncivil to systematically deny access to health care to a segment of our population on the sole basis of their socioeconomic status. We continue to feel that the only way to pay for expanded health care access is to profoundly and substantially reduce the administrative costs of the current health care system through a reorganization and simplification of the health care bureaucracy. We continue to believe that individual patients need to have autonomy and control of the health care decisions that affect their lives. We continue to believe that there should be no commercial profit made from the care of patients.

**We call on the Legislature to clearly declare that access to health care is a right for the residents of the Commonwealth of Massachusetts.**

We believe in a health care system established and sustained in the interests of patients and families.

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We call on the legislative and executive branches of the Commonwealth of Massachusetts to establish a special state health care commission with the explicit purpose of developing a staged and sequenced plan to take our state to a system of universal health care coverage for all state residents within 5 years. This commission would be bipartisan in leadership and comprised of representatives from all stakeholder organizations.

We have drafted a set of principles for health care reform, which we feel should govern this process and have attached these as an appendix.

We offer the following comments with respect to the LECG report submitted to the Advisory Committee:

1) Only Model 3 would provide for universal health care access. Model 1 would continue a multi-class health care system and would be unsustainable given the vagaries of state and federal funding. Model 2 would require massive changes in the tax law and a new system of enforcement.

2) LECG has laid the groundwork for the next phase of state-based health care reform. Importantly the consultant gave each of the stakeholders an opportunity to express their expectations from the health care reform process. This necessary step needs to be expanded and deepened. The critical stakeholders need to be meaningfully engaged in a creative discussion of what the health care system should be for the state. These stakeholders include the public, the payors (including large and small businesses, financial institutions, and the state), and the providers (including all professional groups, the health institutions, and the provider groups).

3) The base model powerfully delineates the administrative waste of our current system. With 39% of the health care dollar going to administration a substantial amount of funding intended for patient care is lost to an inefficient bureaucracy. Maintaining access for those with health care coverage and expanding access to those with limited coverage or no coverage at all demands a reengineering of the current health care bureaucracy.

4) LECG did not fully expand the range of more profound changes in health care administration. For example, $8 billon could be saved by a 50 % reduction in administrative costs. Perhaps even more could be saved with more creative planning. LECG did illustrate that $1.7 billion could be saved from a modest consolidation through a Single Payor Authority as described in their report.

5) LECG did not address the implications of the current employment-based payment system for health care and the pros and cons of alternative payment mechanisms. It was assumed that there would continue to be a variety of revenue sources including business, government, individual and philanthropic. As a state, we need to consider whether alternative revenue collection models would be more equitable or efficient and how this would affect the state's economy, positively or negatively.

6) LECG did not specifically address the administrative needs of the "ideal" health care system. We would suggest this as an important exercise involving all stakeholders in order to establish a template for comparison to the current redundant and inefficient system. We would propose reorganization around specific administrative functions. For example, consolidated information systems should allow for credentialing, system quality surveillance, and resource allocation assessment.

We wholeheartedly endorse the process of deliberate and planned change in the health care delivery system. We have begun this process with the LECG report, the first state-commissioned plan for health care reform. Public support for health care reform in order to achieve universal access is high, roughly 80% in Massachusetts.

We have devoted enormous resources to the healing of our selves and our fellow state residents, but we have an imperfect, inadequate, and inefficient system. Now is the time to begin the next phase of change to a more equitable and more effective system of health care delivery.

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## Principles of Health Care

**Health Care in the United States is changing, for better and for worse. As clinicians, citizens and patients, we are committed to maintaining and improving the health of our patients. We are deeply concerned about the changes for the worse regarding limits to access, profits made by health care organizations that drain resources away from patient care, the distortion of clinical decision-making by financial considerations, and the squandering of valuable and finite resources on paperwork and bureaucracy. We offer these principles as fundamental components of health care practice and organization.**

**Health Care Broadly Defined:** We define health care broadly to include the prevention, diagnosis, treatment and management of illness including medical, surgical and mental. We consider health promotion, rehabilitation, and palliation as essential services. Health care is fundamentally based on personal, professional and trusting relationships between individuals seeking care and those who care for them. Health care organizations and institutions should exist primarily to improve the health of patients.

**Access:** Health care should be accessible to all regardless of employment, education, social, economic, cultural or linguistic status. Financial, geographic, and organizational barriers should not limit access to care. The ability to creatively and appropriately employ scientific and technologic innovations in the interests of patients should be facilitated and enhanced by health care organizations and institutions.

**Choice:** Patients must have the right to choose their health care organizations and their clinicians within these organizations.

**Confidentiality:** Personal medical information must be confidential and accessible, in a timely fashion and with the patient's permission, only to those responsible for the patient's care and only in the patient's interest.

**Responsible Health Care Organizations:** There should be no profit made from the care of patients. Health care organizations are accountable to the patients they serve. Any resources saved by system efficiencies and improvements should be reinvested in the care of patients and not returned to investors. Competition among health care organizations is helpful only when it improves the care of patients.

**Responsible Professionals and Patients:** As professionals and patients, we must responsibly allocate the finite resources available for health care. The legal, ethical and moral obligation of clinicians to provide care in accordance with the highest professional standards is fundamental. Those who take action to correct conditions that prevent safe practice or high quality patient care must not suffer discipline or dismissal for their actions.

**Disclosure:** There should be full disclosure available to patients and the public of the financial arrangements between health professionals and health care organizations and between organizations and for-profit corporations. The licensure and job title of every person providing direct care should be clearly evident to patients and family.

**Quality and Peer Review:** Health care should be subject to review by peers and the public. This includes easy access for patients and clinicians to expert and second opinions.

**Research and Training:** Research and professional training are essential to the long-term vitality of our health care system. Both require the explicit support of all health care organizations and local, state and federal governments.

**Simplicity and Clarity:** Health care should be delivered and paid for in the simplest fashion possible. Repetitive and complex paperwork, administrative delays, and confusing forms distract clinicians from the care of patients and are unnecessary barriers to the effective and efficient delivery of health care.

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